Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS46ADC	A. BUILDING _____ B. WING _____	C 08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PALMS MEMORY CARE 2	4025 S. PEARL STREET LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on August 1, 2008. This state licensure survey was conducted using Chapter 449 of the Nevada Administrative Code (NAC), last adopted by the Nevada State Board of Health on 06/23/86. The facility was licensed as a forty (40) client facility which provides care for adults during the day (ADC) At the time of the survey, the census was seven (7) clients. There were two complaints investigated. Complaint # NV13166 was substantiated Complaint # NV10845 was unsubstantiated. These findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	U 000		
U 65 SS=G	449.40723 SUPERVISION OF CLIENTS; VOLUNTEERS 1. A client must be supervised by an employee of the facility at all times during the operating hours of the facility. The employee shall report a change in any physical, mental, emotional or social function of the client to the director of the facility. These reports must be included in theclient's file.	U 65		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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U 65	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to maintain documentation of injuries and/or falls for 1 of 7 clients (#1). Findings include: Client #1 was a 71 year old female attending the ADC (Adult Day Care) for one year with a diagnosis of schizophenia and dementia. Interview: On 08/01/08 in the morning, the Director of Nursing (DON) was interviewed concerning Client #1's injury. She indicated that she was not working at the facility when the incident occured. She was unable to locate the documentation regarding the fall. Record Review: Review of a letter from MedicWest Ambulance indicated that client #1 was transported from 4025 S. Pearl Street, Las Vegas, NV at approximately 4:40 PM on October 1, 2006 to UMC (University Medical Center) Emergency Room. Review of the records from UMC on 10/01/06 indicated the client sustained a right femoral neck fracture due to a fall at the facility. The facility lacked documentation of an incident report or nurses notes concerning the fall which occured at the facility on 10/01/2008 that resulted in client #1 sustaining a right femoral neck fracture.	U 65		

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U 65	Continued From page 2 Severity 3 Scope 1	U 65		